Statement of Deficiencies

8815-B,C: Governing Body **Not Met**

Findings/Corrections

8815 C. 3. The governing body of the Provider failed to ensure that the Provider was adequately funded and fiscally sound. THERE IS NO BOARD APPROVAL OF THE BUDGET.
8815 C. 4. The governing body of the Provider failed to review and approve the Provider's annual budget. THERE IS NO BOARD APPROVAL OF THE BUDGET.
8815 C. 6. The governing body of the Provider failed to formulate and annually review, in consultation with the administrator, written policies concerning the provider's philosophy, goals, current services, personnel practices, job descriptions and fiscal management. MANY POLICY CHANGES HAVE OCCURED AND BEEN IMPLEMENTED SINCE NOVEMBER WITHOUT THE WRITTEN APPROVAL OF THE GOVERNING BODY.

8817-F: Orientation **Not Met**

Findings/Corrections

8817 F. 1. (a.-.e.) The Provider's orientation program failed to include training in the following topics for staff [TB]: a) the policies and procedures of the facility; b) emergency and evacuation procedures; c) resident's rights; d) procedures for and legal requirements concerning the reporting of abuse and critical incidents; and e) instruction in the specific responsibilities of the employee's job.
8817 F. 2. (a.-c.) Orientation for direct care staff, [TB], failed to include an additional five days of supervised training in the following: a) resident care services (ADLs and IADLS) provided by the facility; b) infection control to include blood borne pathogens; and c) any specialized training to meet residents' needs.
8817 F. 3. A new employee, [TB], was given sole responsibility for the implementation of a client's program plan before the five day supervised training was completed.
8817 F. 4. A staff member, [TB], failed to sign a statement certifying that orientation and the five day supervised training had occurred.

8817-I: Personnel Files **Not Met**

Findings/Corrections

8817 I. 1. (d h i.) The Provider failed to maintain a personnel record for each employee identified below d. documentation of TB test results [SL TB];
h. documentation of orientation [TB];
i. documentation of driver's license, [CO].

8817-J: Resident's Records **Not Met**

Findings/Corrections

8817 J. 1. The provider failed to maintain a separate, current and complete record for each resident, in the facility or in a central administrative location readily available to facility staff and to the Bureau of Licensing staff. THE CLIENT RECORDS WERE NOT COMPLETE AS EVIDENCE BY CARE PLANS WERE KEPT IN A SEPARATE FOLDER IN THE RESIDENT CARE COORDINATOR'S OFFICE AND ADDEDUMS TO THE LEASES FOR RESIDENT'S ADMITTED AFTER 11-03 WERE KEPT IN THE DIRECTOR'S OFFICE.
8817 J. 2. (a.-o.)8817 J. 2. (a.-o.) Each resident's record failed to include:
h. the preadmission appraisal and admission agreement,
i. reports of the assessment specified in 8827.A.1 and of any special problems or precautions;
j. individual service plan, updates, and quarterly reviews;

8817-K: Records **Not Met**

Findings/Corrections

8817 K. 1. All records failed to be maintained in an accessible, standardized order.

Statement of Deficiencies

8821-A: Resident's Rights **Not Met**

Findings/Corrections

8821 A. 4. A copy of residents' rights failed to be posted conspicuously in the facility. THE COPY OF THE RIGHTS DID NOT INCLUDE HOUSE RULES.

8821-G: Critical Incidents **Not Met**

Findings/Corrections

8821 G. 1. The Provider failed to have written procedures for the reporting and documentation of unusual incidents and other situations or circumstances affecting the health, safety or well-being of a resident or residents. (i.e., death of unnatural causes, injuries, fights or physical confrontations, situations requiring the use of passive physical restraints, suspected incidents of abuse or neglect).

8821-H: Abuse and Neglect **Not Met**

Findings/Corrections

8821 H. (1.-6.) The Provider failed to have comprehensive written procedures concerning resident abuse and neglect to include provisions for:
1) training and maintaining staff awareness of abuse prevention, current definitions of abuse and neglect, reporting requirements and applicable laws;
2) ensuring that regulations stipulated in 8821.G.3 for reporting critical incidents involving abuse and neglect are followed;
3) ensuring that the administrator completes an investigation report within 10 working days;
4) ensuring that the resident is protected from potential harassment during the investigation;
5) disciplining staff members who abuse or neglect residents; and
6) protecting residents from abuse inflicted by other residents or third parties, including, but not limited to, criminal prosecution of the offending person and his/her permanent removal from the facility.

8823-B: Preadmission Appraisal **Not Met**

Findings/Corrections

8823 B. 1. (a.-c.) The Provider failed to complete and maintain a preadmission appraisal on each applicant assessing the applicant's needs and appropriateness for admissions including:
c. the resident's ability to evacuate the facility in the event of an emergency. FACILITY IS IN THE PROCESS OF REVISING THE PREADMISSION FORM. THE PRE ADMISSION ASSESSMENT FORM IN THE POLICY MANUAL IS NOT THE FORM BEING USED.

Statement of Deficiencies

8823-C: Admissions Agreement **Not Met**

Findings/Corrections

8823 C. 1. (a.-l.) The Provider failed to complete and maintain individual written admission agreements with all persons admitted to the facility or with their legally responsible person or person specifying:
a. clear and specific occupancy criteria and procedures (admission, transfer, and discharge);
b. basic services to be made available;
c. optional services which are available;
d. payment provisions, including the following:
i. covered and noncovered services;
ii. service packages and "a la carte" services;
iii. regular and extra fees;
iv. payor;
v. due date; and
vi. funding source, provided that the resident may refuse to disclose sources;
e. modification conditions, including provision of at least 30 days prior written notice to the resident of any basic rate change, or for SSI/SSP rate changes, as soon as the provider is notified. Agreements involving persons whose care is funded at government prescribed rates may specify that operative dates of government modifications shall be considered operative dates for basic service rate modification; AGREEMENT DOES NOT INCLUDE THIS.
f. refund conditions;
g. that the Bureau of Licensing has the authority to examine residents' records as part of the evaluation of the facility.
h. general facility policies which are for the purpose of making it possible for residents to live together, including policies and rules regarding third-party providers arranged by the resident (the use of private duty nurses or assistants);
i. division of responsibility between the facility, the resident, family, or others (e.g., arranging for or overseeing medical care, purchase of essential or desired supplies, emergencies, monitoring of health, handling of finances);
j. residents' rights;
k. explanation of the grievance procedure and appeals process, including information on outside agencies to which appeals may be made; and
l. the availability of a service plan specific to the individual resident. FOR RESIDENTS ADMITTED AFTER 11/03, FACILITY CONTINUED TO USE A LEASE AGREEMENT THAT STATED ALL BASIC SERVICES NEEDED WERE INCLUDED IN THE BASIC RATE IF IDENTIFIED AT TIME OF SIGNING. HOWEVER FACILITY BEGAN ASSESSING THE RESIDENTS ABILITY TO PERFORM BASIC NEEDS AND CHARGING ACCORDING TO ASSISTANCE PROVIDED BY THE FACILITY. THE FACILITY RATES THE RESIDENTS ABILITIES AND USES A POINT SYSTEM. FOR EACH POINT ASSESSED, A $25 POINT CHARGE IS ADDED TO THE BASIC RATE. ACCORDING TO STAFF THIS ASSESSMENT WILL BE DONE QUARTERLY, AND A COST ADJUSTMENT WILL BE MADE AS NEEDED.
8823 C. 3. The admissions agreement failed to be signed by the director and by the resident and the representative, if applicable.

8825-D: Discharge Records **Not Met**

Findings/Corrections

8825 D. 1. (a.-c.) Discharge information failed to be recorded in a resident's record including:
a. date of discharge; b. destination, if known; and
c. reason(s) for leaving, if known. IN ONE OF TWO RECORDS REVIEWED.

Statement of Deficiencies

8827-A: Assessment, Service Coordination and Monitoring **Not Met**

Findings/Corrections

8827 A. 2. The Provider failed to develop a service plan within 30 days after admission with input from the resident and/or his/her representative and using information from the assessment. IN TWO RECORD REVIEWED.
8827 A. 3. The service plan failed to be responsive to the resident's needs and preferences. NOT ALL RESIDENT'S SERVICE PLANS ARE NOT COMPLETE. THERE ARE MANY BLANK AREAS.
8827 A. 4. (a.-c.) The service plan failed to include:
b. the scope, frequency, and duration of services and monitoring that will be provided to meet the resident's needs; and

8827 A. 5. The resident's service plan failed to be revised and signed by the resident and the representative, when applicable, and the designated facility staff when a resident's condition or preferences changed.
8827 A. 6. The service plan failed to be monitored on an ongoing basis to determine its continued appropriateness and to identify when a resident's condition or preferences changed. There failed to be a documented review of the service plan at least every quarter.
8827 A. 7. Each service plan and review failed to be signed by the resident, facility staff, and the representative.

8827-C,D: Medications and Health Related Services **Not Met**

Findings/Corrections

8827 C. 1. The Provider failed to have clear written policies and procedures on medication assistance. STAFF WERE OBSERVED NOT FOLLOWING THE PROVIDER'S CURRENT POLICY.
8827 C. 2. The Provider failed to assist residents in the self-administration of prescription and non-prescription medication as agreed to in their contract or service plan and as allowed by state statute/regulations. *STAFF WERE OBSERVED POURING MEDICATION FROM BOTTLES INTO MEDICATION CUP. ** STAFF WERE OBSERVED PUNCHING MEDICATION FROM BLISTER PACKS INTO A MEDICATION CUP. ***FOR ONE RESIDENT, STAFF DISPENSED MEDICATION FROM BLISTER PACKS AND MEDICATION BOTTLE AT A CENTRAL LOCATION AND THEN TOOK THE MEDICATION CUP CONTAINING THE MEDICINES TO THE RESIDENT'S APARTMENT FOR ADMINISTERING. ****ONE RESIDENT IS NOT PHYSICALLY CAPABLE OF ADMINISTERING MEDICATION AND IS NOT COGNITVE OF WHAT THE MEDICATION IS, WHAT IT IS FOR AND THE NEED FOR THE MEDICATION. *****DURING FIVE MEDICATION OBSERVATIONS, THE DIRECT CARE STAFF WAS OBSERVED DISPENSING AND ADMINISTERING MEDICATIONS. SHE TOOK MEDICATION FROM THE MEDI-SET BOXES AND POUR THEM INTO A MEDICATION CUP. SHE HANDED THE CUPS TO THE RESIDENTS WHO THEN TOOK THEIR MEDICINE. THESE RESIDENTS ARE NOT SELF- ADMINISTERING THEIR MEDICATIONS.
8827 C. 3. (a.-e.) Assistance with self-administration of medications failed to be limited to the following:
a. The resident may be reminded to take his/her medications.
b. The medication regimen, as indicated on the container may be read to the resident.
c. The dosage may be checked according to the container label.
d. The staff may open the medicine container (i.e., bottle, mediset, blister pak, etc.), if the resident lacks the ability to open the container.
e. The resident may be physically assisted in pouring or otherwise taking medications, so long as the resident is cognitive of what the medication is, what is for and the need for the medication. SEE 8827 C 2.

THE PROVIDER IS PLANNING THE FOLLOWING WHIICH ARE NOT ALLOWED BY THESE REGULATIONS:
**** PROVIDER IS GOING TO LEASE A ROOM TO A HOME HEALTH AGENCY. THE ROOM WILL HAVE NO STAFF BUT WILL BE A DROP-SITE WITH A DESK AND A FAX MACHINE.***
*****THE PROVIDER IS PLANNING TO WORK WITH ANOTHER HEALTH CARE AGENCY TO ALLOW THEM TO USE THE RESIDENTS EXERCISE ROOM TO PROVIDE THERAPY.***
******THE PROVIDER PLANS TO HIRE A PHYSICIAN ON RETAINER TO COME INTO THE FACILITY ONE DAY A WEEK TO BE AVAILABLE TO THE RESIDENTS AS NEEDED.***

Statement of Deficiencies

8827-E: Transportation **Not Met**

Findings/Corrections

8827 E. 3. The Provider failed to document and ensure that drivers had a valid Louisiana driver's license, that drivers had a clean driving record, and that they were trained/experienced in assisting residents.

8827-F: Meals **Not Met**

Findings/Corrections

8827 F. 2. (a.-e.) The Provider failed to make reasonable accommodations, as contracted for by the residents, to:
a. meet dietary requirements;
ONE RESIDENT WITH A GLUTIN FREE DIET HAS SIGNED A LEASE WITH THE AGREEMENT THAT THREE MEALS A DAY WILL BE PROVIDED. THIS RESIDENT CANNOT EAT SOME OF THE FOODS SERVED SO SHE PROVIDES THE COOKS WITH HER SPECIAL DIETARY FOODS AND THEY PREPARE THE FOOD FOR HER.

8827-G: Menus **Not Met**

Findings/Corrections

8827 G. 2. The Provider failed to furnish medically prescribed diets to residents for which it contracted either in the contract or in the service plan. Menus for medically prescribed diets failed to be planned or approved by a registered licensed dietitian. ONE RESIDENT IS ON A 1800 CALORIE DIET AND ONE RESIDENT IS ON A GLUTIN-FREE DIET. THE DIETITIAN HAS NOT DEVELOPED APPROPRIATE DIETS FOR THESE TWO RESIDENTS.
8827 G. 1. Menus failed to be planned and written at least one week in advance and dated as served. The current week's menu failed to be posted in one or more conspicuous places in the facility. THE CURRENT WEEKS MENU IS POSTED IN THE KITCHEN